Vogtle 1
2Q/2005 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2005
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Properly Sequence Plant Activities Causes Unanticipated Reactor Coolant System Drain Path
A self-revealing non-cited violation (NCV) was identified for failure to properly sequence plant activities which resulted in an unanticipated Unit 1 reactor coolant system (RCS) drain path.

This finding is of greater than minor significance because it affected the configuration control attribute of the initiating events cornerstone and affected the cornerstone objective in that it created an unanticipated RCS drain path. The finding is of very low safety significance (Green) because it did not contribute to the likelihood that any mitigation equipment or functions would not be available. The residual heat removal system remained operable during the transient and a large volume of makeup water was available. This finding also involved the cross-cutting aspect of human performance, in that, the improper sequencing of activities created an unanticipated drain path.
Inspection Report# : 2005002*(pdf)*

Mitigating Systems

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Significance: N/A Nov 19, 2004
Identified By: NRC
Item Type: FIN Finding

Biennial Problem Identification and Resolution Inspection Summary
The inspection team determined that the licensee was identifying plant deficiencies at an appropriate low level and entering them into the corrective action program. After reviewing condition reports, conducting system walkdowns, and examining equipment tracking databases, the team identified some minor deficiencies. During system walkdowns, the inspectors identified three minor conditions adverse to quality that had not been identified by the licensee. Also, inspectors identified several minor documentation discrepancies. Quality Assurance audits were effective at identifying issues at a very low level. The licensee adequately prioritized issues and evaluations were technically accurate and of sufficient depth. Formal root cause evaluations using widely accepted methods were adequate in determining the root and contributing causes of problems. Corrective actions to fix problems were appropriate and timely. Because the licensee had identified a number of problems related to human error which were not restricted to any one group, the licensee had implemented a site wide human performance improvement initiative. The inspectors did not identify any reluctance on the part of the employees to document safety concerns in the corrective action program.
Inspection Report# : 2004008*(pdf)*

Last modified : August 24, 2005